IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

VERITA GILL, Plaintiff, v. COMMISSIONER of Social Security, Defendant.	No. CV-07-812-HU FINDINGS & RECOMMENDATION

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HUBEL, Magistrate Judge:

Plaintiff Verita Gill brings this action for judicial review of the Commissioner's final decision to deny supplemental security income (SSI). This Court has jurisdiction under 42 U.S.C. §§ 405(g) and 1383(c)(3). I recommend that the Commissioner's final decision be reversed and remanded for a determination of benefits.

PROCEDURAL BACKGROUND

Plaintiff applied for SSI on December 10, 2001, alleging an onset date of November 1, 2000. Tr. 179. Her application was denied initially and on reconsideration. Tr. 124-25. On October 30, 2003, plaintiff appeared, with counsel, at a hearing before an Administrative Law Judge (ALJ). Tr. 882-923. On December 23, 2003, the ALJ found plaintiff not disabled. Tr. 741-51.

On June 1, 2005, the Appeals Council remanded the decision for additional evidence concerning plaintiff's physical and mental impairments, to determine whether drug addiction is a contributing factor to disability, and to review treating and examining source medical records. Tr. 762-64.

On September 21, 2005, the ALJ conducted a second hearing at which plaintiff appeared with counsel. Tr. 924-59. On November 16, 2005, the ALJ again found plaintiff not disabled. Tr. 107-22. The Appeals Council denied plaintiff's request for review of the second ALJ decision. Tr. 9-12.

FACTUAL BACKGROUND

Plaintiff alleges disability based on a combination of physical and mental impairments, including mental retardation and personality disorder, bipolar disorder, depression, post-traumatic stress disorder (PTSD), anxiety-related disorder, depression, degenerative disk disease, Hepatitis-C, and substance abuse disorder in partial remission. Tr. 587, 615. At the time of the hearing in September 2005, plaintiff was forty-nine years old. See Tr. 179 (noting plaintiff's date of birth as 1956). Plaintiff has a high school education. Tr. 249.

I. Medical Evidence

The earliest medical evidence in the record shows that in February 1994, plaintiff voluntarily admitted herself to Woodland Park Hospital, following two suicide attempts in the previous ten days. Tr. 711. Plaintiff was hospitalized for eleven days, and then discharged on no medications, but with a recommendation to follow up at the Oregon Health Sciences University (OHSU) Psychiatric Clinic, and to become involved with "Project Network"[1] for certain social services. Tr. 712. Plaintiff had improved during the course of her hospital day, with daily individual psychotherapy sessions. Id. She chose not to try a course of anti-depressants because she was pregnant at the time and worried about the effects of the medication on the fetus. Id.

Next, the record contains a ten-page "Multnomah Clinical

[1] Other evidence in the record indicates that Project Network is an inpatient alcohol and drug treatment center. E.g., Tr. 353 (referring to Project Network as a residential drug and alcohol treatment facility).

Assessment" which appears to have been from the fall of 1998. Tr. 323-32. The purpose of this assessment is unclear. Linda Kolokolo, Licensed Clinical Social Worker, is identified as the evaluator. Tr. 325. Kolokolo indicated that plaintiff stated she had depression while in jail, and that she faced stress from homelessness, separation/divorce, and being arrested. Tr. 324. Other notes indicate a problem with cocaine dependence, as well as a history of emotional and physical abuse by a spouse, and molestation as a child. Tr. 325-26.

In an "Entry Progress Form," completed by Multnomah County Corrections Health staff on February 11, 1999, it is noted that plaintiff was a client of Project Network at the time and that she was taking trazodone[2]. Tr. 401.

In April 1999, Dr. Matt Bazell, M.D., Medical Director at Project Network, reviewed and approved an assessment of plaintiff done by Kolokolo in late January 1999. Tr. 333-46. There, Kolokolo noted that plaintiff had symptoms of depression, anxiety, and post-traumatic stress disorder, including a history of suicide attempt in the last year, sleep disturbance, lack of energy, loss of appetite, mood swings, difficulty concentrating, headaches, visual hallucinations, paranoia, and exposure to traumatic event (being a victim of domestic violence). Tr. 344. While she exhibited these symptoms, none had persisted long enough, in Kolokolo's opinion, to support them as a conclusive diagnosis. Id. Kolokolo noted that due to plaintiff's recent recovery from substance abuse, plaintiff would benefit from further evaluation in

[2] An antidepressant drug. www.medicinenet.com

thirty days to see if her symptoms persisted, or perhaps increased or decreased. Id.

On July 9, 1999, psychologist Gary Sacks, Ph.D., examined plaintiff for Disability Determination Services (DDS). Tr. 347-52. He concluded that she suffered from chronic major depressive disorder, mild to moderate, and polysubstance abuse, six months into remission by plaintiff's report. Tr. 352. He stated that she had borderline personality traits and that borderline intellectual functioning needed to be ruled out. Id. He commented that plaintiff's intellectual ability was estimated to lie in the borderline to low average ranges based upon her educational and occupational attainments. Id. He further stated that her ability to demonstrate her intellect may be suppressed by her depressed mood. Id.

On July 7, 1999, and again on July 15, 1999, psychologist Sandra Jenkins, Ph.D., examined plaintiff while plaintiff was an inpatient at Project Network. Tr. 353-357. Dr. Jenkins interviewed and observed plaintiff, and administered several tests, including the Wechsler Adult Intelligence Scale-Revised (WAIS-R), and the Minnesota Multiphasic Personality Inventory (MMPI). Tr. 353. Dr. Jenkins concluded that plaintiff presented a "complex and contradictory portrait." Tr. 356. Dr. Jenkins noted that because of plaintiff's poor self-esteem and poor self-confidence, she "protects herself by refusing to give her best effort to any task where failure is a possibility." Tr. 356. Therefore, it was difficult to draw conclusions about her true abilities. Id.

Dr. Jenkins noted that plaintiff's full scale IQ score put her in the borderline range. Tr. 385. She concluded that it was

likely that plaintiff had some learning disability or cognitive impairment, but current testing could not confirm that. Tr. 386. Dr. Jenkins diagnosed plaintiff with PTSD, dependent personality disorder with anti-social features, and cocaine dependence, in remission. Id.

Dr. Jenkins recommended that plaintiff be scheduled for a complete physical and neuropsychological work-up, including a CT scan to assess possible brain impairments, and testing for learning disabilities. Id. She further recommended neuropsychological testing to distinguish between attention deficit disorder, memory impairment (explicit and implicit memory test), and malingering. Tr. 357.

In July 2000, plaintiff broke her right foot. X-rays showed a fracture at the base of the right fifth metatarsal, and the proximal right fifth metatarsal. Tr. 497, 498. On July 7, 2000, plaintiff was examined by Dr. David Noall, M.D. of the Portland Bone and Joint Center. Tr. 426. He put her in a short leg walking cast, with weight-bearing as tolerated. Id.

Plaintiff was treated by Dr. Noall for this injury through October 19, 2000. Tr. 421. During that time, she used a "fracture walker" and eventually a cane for walking. Id. At her last visit with him for this injury, Dr. Noall found no residual swelling, mild diffuse tenderness around the base of the fifth metatarsal, and moderately severe pain behavior. Id. X-rays showed the fracture was united and no fracture lines were visible. Id. Dr. Noall continued an earlier recommendation that she do sedentary work and minimal walking. Id.

During the time Dr. Noall was treating plaintiff's foot,

plaintiff underwent a CT guided liver biopsy as a result of a positive Hepatitis-C test. Tr. 487. The test showed no abnormality of the liver or spleen. Id.

On January 23, 2001, plaintiff went to the emergency room for left ankle pain as a result of a fall. Tr. 452. X-rays of the ankle and foot showed no fractures or dislocations. Tr. 493. She was diagnosed with a sprain, given a splint, and told to follow up with Dr. Noall. Tr. 453.

Plaintiff saw Dr. Noall on February 5, 2001. Tr. 419-20. Plaintiff complained that the ankle was still quite painful. Tr. 419. Dr. Noall found mild soft tissue swelling around the anterior lateral malleolus. Id. He indicated that she should continue using a crutch. He placed her in a short leg walking cast and told her that she could bear weight as tolerated. Id. He limited her to sedentary work with minimal walking, for six to eight weeks. Tr. 420. Dr. Noall's records indicate that after he saw her on February 5, 2001, she failed to make a follow up appointment until April 2001, when she saw him for a recurrent left ankle sprain. Tr. 417.

On April 18, 2001, plaintiff sought emergency treatment for another left ankle sprain. Tr. 445. She reported falling down stairs and twisting it. Id. Plaintiff was diagnosed with a left ankle sprain, was prescribed Vioxx and Vicodin, and given an air cast. Tr. 582.

Plaintiff saw Dr. Noall on April 26, 2001, presumably for follow-up evaluation and treatment. Tr. 417. He noted that there was diffuse lateral malleolar tenderness with left ankle equivocal swelling. Id. He also noted the presence of mild pain behavior.

Id. He noted that x-rays taken at Emanuel Hospital on April 19, 2001, were normal. He diagnosed her with a recurrent left lateral ankle sprain. Id. He gave her a short leg walking cast, instructed her to use a crutch, and to bear weight as tolerated. Id. He also prescribed Vicodin, but indicated it would not be refilled. Id. Dr. Noall's notes indicate that he gave plaintiff a note indicating she should do sedentary work, minimal walking, with crutches, and that the estimated length of treatment was four to six weeks. Id.

Plaintiff followed-up with Dr. Noall on May 22, 2001. Tr. 414. He noted that she was improved and physical examination showed trace tenderness. Tr. 414. He discontinued the cast, gave her an air splint, and gave her a note indicating she should do sedentary work with minimal walking. Id. The estimated time of this treatment was two to four weeks. Id.

On September 7, 2001, a Multnomah County Corrections Health nurse noted that plaintiff was depressed because of her incarceration and her family situation. Tr. 390. Her husband had attacked her and cut her with a knife. Id. Her children do not get along with him. Id. The attack made her marriage worse, but plaintiff wanted to work things out. Id. She apparently had been using crack for two to three years, with her last use on August 29, 2001. Tr. 389. The nurse assessed plaintiff as suffering from depression. Tr. 388.

On September 10, 2001, plaintiff was seen by Scott Haynes, Corrections Health Psychiatric Mental Health Nurse Practitioner. Tr. 386-87. She reported being clean from drugs for three years, but relapsing on alcohol and crack cocaine shortly before her

incarceration. Tr. 386. Haynes noted that plaintiff had a crying spell, dysphoric mood, and highly limited eye contact. Id. He noted that she expressed feeling overwhelmed in three areas: her children and their return to their father, her husband's drug abuse and subsequent physical abuse, and pending legal action against her. Id. He noted that her expressed thoughts demonstrated little insight and/or poor judgment, into the seriousness of her husband's behaviors. Id. Haynes assessed her as suffering from polysubstance dependence, and adjustment disorder with mixed anxiety and depression. Tr. 387. He prescribed doxepin[3] to promote sedation, lift her mood, and decrease her anxiety. Id.

On September 11, 2001, Corrections Health Nurse C. Borgmeier, R.N., completed a health assessment of plaintiff. Tr. 404-05. Plaintiff noted that she had broken her feet in 2001 and had painful ambulation. Tr. 405. She referred to a habit of smoking cocaine, but denied ever sharing needles. Id. She stated that in the past, she had been depressed enough to ask for help and had attempted suicide. Tr. 404.

On November 21, 2001, plaintiff was examined by Dr. Noall for a right foot injury. Tr. 412. She heard a "pop" and experienced pain. Id. On physical exam, Dr. Noall found slight lateral forefoot swelling, and mild tenderness around the distal fourth and fifth metatarsals. Id. X-rays revealed no fractures. Id. His diagnosis was post-traumatic right foot pain, with no evidence of fracture or dislocation. Id. He provided plaintiff with a

[3] A tricyclic antidepressant medication. www.medicinenet.com

Stromgren ankle support, told her to bear weight as tolerated, and prescribed Vicodin. Id. He also said she should engage in limited standing and walking, and gave her a note indicating that she should be on the lower bunk of the domestic violence shelter where she was residing. Id.

On January 2, 2002, plaintiff went to the OHSU emergency department complaining of severe neck and back pain after falling on December 21, 2001, while getting on a bus. Tr. 428. On physical exam, plaintiff had tenderness to palpation along the bilateral paraspinal muscles, particularly tenderness along the trapezius extending towards the suprascapular region. Id. She had full range of motion of the neck. Id. Tenderness was also seen along the L4-L5 parapsinal muscles. Id. The emergency department physician concluded that plaintiff had a significant strain and spasm of her paraspinal muscles. Tr. 429. Plaintiff received a prescription for Valium and Vicodin. Id.

Plaintiff then received chiropractic care for her injuries related to this incident, from Zchon R. Jones, D.C., beginning on January 23, 2002, and lasting until April 8, 2002. Tr. 525-41. She received a variety of therapies, including massage, hot packs, trigger point therapy, and chiropractic adjustments. Tr. 534-36. At the end of her treatment, plaintiff reported a "significant resolution of the majority of her original complaints." Tr. 527. Although she noted she still had "up and down" days, she reported that overall, she felt better. Id.

Between January 11, 2002, and February 22, 2002, plaintiff met with social worker J. Workman-Purvine, MSW, at Jean's Place, a women's facility run by Transition Projects, Inc., an agency

serving Portland's homeless citizens. Tr. 501-09. Over the course of the approximately six weeks of counseling sessions, Workman-Purvine noted that plaintiff presented with numerous symptoms of depression and anxiety, although it was unclear if her symptoms were Axis I symptoms or Axis II traits. Id. Workman-Purvine noted plaintiff's reports of feeling overwhelmed, and of experiencing panic attacks. Tr. 507, 508.

Workman-Purvine assessed plaintiff as having a history of polysubstance abuse, and then indicated a rule out bipolar II disorder mixed episode, and a rule out anxiety disorder, nos. Id. Workman-Purvine stated that despite plaintiff's denial of manic or hypomanic episodes, Workman-Purvine observed symptoms that might indicate a hypomania, including flight of ideas, distractability, and decreased need for sleep. Id. Workman-Purvine noted that the subjective reports of depressive symptoms might indicate the possibility of a "mixed episode." Id.

On February 1, 2002, plaintiff reported feeling more depressed, noting symptoms that included alternating insomnia and hypersomnia, fatigue, irritability, poor concentration, feelings of numbness, and mild suicidal ideation with no current plan or intent. Tr. 506. She also reported persistent worrying and more panic attacks. Id.

Workman-Purvine stated that plaintiff continued to present with significant affect instability. Id. Though plaintiff's symptoms mimicked a mixed episode, Workman-Purvine could not establish enough symptoms to warrant a diagnosis for mania or hypomania. Id. Workman-Purvine indicated that plaintiff's anxiety symptoms most resembled a panic disorder. Id. The assessment of

plaintiff at the time was a mood disorder, nos, and rule out panic disorder with agoraphobia. Id.

On February 8, 2002, plaintiff's depressive symptoms were noted as increasing, despite her having started on doxepin and Zoloft[4], which she apparently received from a walk-in mental health clinic. Tr. 505. Workman-Purvine was concerned about plaintiff possibly attempting suicide. Id. A couple of weeks later, on February 15, 2002, plaintiff reported an improvement in her overall mood and believed that the anti-depressants were beginning to work. Tr. 503. She reported improved sleep, greater ease in waking up, more energy, and a greater sense of hope. Id. Workman-Purvine continued to assess plaintiff as having a mood disorder, nos, and rule out panic disorder with agoraphobia. Id. She also added rule out PTSD. Id.

In her final appointment with Workman-Purvine, plaintiff reported three deaths in her family in the previous week, rendering her numb. Tr. 502. Workman-Purvine stated that she was concerned plaintiff might once again spiral into a depressive episode. Id.

During the time plaintiff was seeing Workman-Purvine, it appears that she made contact with Network Behavioral HealthCare, Inc., run by Cascadia Behavioral HealthCare.[5] Tr. 592-93. Her

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[4] A selective serotonin reuptake inhibitor (SSRI), used to treat depression and panic disorder. www.medicinenet.com

[5] Network Behavioral Healthcare's address is 2415 SE 43rd Avenue in Portland. Tr. 598. Cascadia has the same address. Tr. 699-700. Additionally, an August 29, 2003 record identifies the Cascadia program as: "Program: Cascadia - NBHC - Network Walk-In Clinic." Tr. 788; see also 792 (record indicating it is an "NBHC Face Sheet" and a "Cascadia Behavioral HealthCare - Clinical Face Sheet").

first contact was on January 31, 2002, and it is unclear if this was in person or by phone. Id. The form reciting the information obtained from plaintiff on that date, is labeled "CallNet Appointment Summary," suggesting this was a phone interview. Id.

On February 1, 2002, plaintiff was seen in Network's Urgent Care Clinic and was started on doxepine and Zoloft. Tr. 520-21, 596-97. Her next visit to Network appears to have been March 18, 2002. At that time, Cynthia Eckersley, Licensed Clinical Social Worker, completed a Treatment Coordination Report for plaintiff, listing her diagnoses as BiPolar II, rule out PTSD, and cocaine dependence in remission. Tr. 598. Eckersley noted that plaintiff presented as depressed and complained of having a nervous breakdown. Id. She reported feeling suicidal. Id.; see also Tr. 511-16, 595 (other notes and assessment by Eckersley).

Plaintiff was also examined by Dr. Vern Read, M.D., at that time. Tr. 601-02. Dr. Read noted that plaintiff had stopped taking the doxepine and Zoloft the previous week, when she ran out of the medications she had received earlier. Tr. 601. She reported to him that she did not feel that the Zoloft had helped at all and while the doxepine had helped her get to sleep, it did not allow her to stay asleep for more than several hours. Id.

Dr. Read noted that plaintiff continued to be quite depressed, labile, and anxious. Id. She had problems with insomnia, difficulty with concentration, and occasionally heard her name called. Id. Dr. Read assessed plaintiff as having chronic depression that may not have responded well to SSRIs. Tr. 602. He noted her family history of bipolar disorder. Id. He also remarked that she had severe polysubstance dependence problems and

likely PTSD. Id. He prescribed Remeron[6]. Id. Although Dr. Read instructed plaintiff to return in two weeks, the record does not show a return visit to Network in that timeframe. A medication management form indicates that she canceled her March 29, 2002 appointment. Tr. 683.

Jane Starbird, Ph.D., examined plaintiff on April 30, 2002, and provided a psycho-diagnostic report. Tr. 542-47. Dr. Starbird based her report on her interview with plaintiff, a mental status exam, the results of the Beck Depression Inventory II, and review of Workman-Purvine's progress notes from January and February 2002. Id. Dr. Starbird diagnosed plaintiff as having major depressive disorder, recurrent and severe, and crack/cocaine dependence in full remission and alcohol dependence in full remission. Tr. 546.

The medication management sheet from Network indicates that Dr. Read renewed plaintiff's Remeron prescription on May 15, 2002. Tr. 683.

On August 20, 2002, plaintiff and Kolokolo signed a "Diagnosis and Treatment Plan" as part of a Project Network Provisional Mental Health Assessment. Tr. 617. The initial part of the report indicates that plaintiff's probation or parole officer recommended that plaintiff complete treatment. Id. She was twenty-four days substance free at the time. Id. Her diagnoses at the time included cocaine dependence, depression nos and PTSD, migraine headaches, with a current stressor being the separation from her children. Id. Kolokolo assessed plaintiff as having a Global Assessment of Functioning (GAF) of 38. Id. The treatment plan

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[6] A tricyclic antidepressant. www.medicinenet.com

included attending certain groups, submitting to random urinalyis tests, attending alcohol and drug individual therapy, and completing a comprehensive mental health assessment. Id.

A more formal treatment plan is dated September 16, 2002, and notes that Cindy Wang, M.A., and Kolokolo were the clinicians. Tr. 618-21. Her diagnoses include alcohol dependence, cocaine dependence, chronic PTSD, bipolar disorder, and psychotic disorder nos. Tr. 618. Additional diagnoses noted were Hepatitis-C, arthritis, neck pains, migraines, and cavities in teeth. Id. A four-page plan of action was outlined, and plaintiff signed that she had participated in the development of the plan with her counselor. Tr. 621.

On September 13, 14, 15, and 20, 2002, plaintiff was evaluated by psychologist George Tinker, Ph.D, at the request of Senior & Disabled Services. Tr. 603-16. Dr. Tinker's fourteen-page report, dated October 6, 2002, began by noting that plaintiff presented with "a number of medical conditions, symptoms suggestive of both a thought disorder and emotional disturbance, cognitive deficits, and history of substance dependence." Tr. 603. Dr. Tinker administered several different tests over the course of his sessions with plaintiff. Tr. 610-13.

Dr. Tinker's diagnostic impressions were that plaintiff suffered from bipolar disorder, PTSD, and cognitive disorder NOS. Tr. 615. He noted that she had alcohol dependence with physiological dependence in a controlled environment and cocaine dependence without physiological dependence in a controlled environment. Id. He also found that she had mild mental retardation and personality disorder NOS, with schizotypal and

borderline traits. Id.

In his narrative conclusion, Dr. Tinker stated that plaintiff functioned intellectually within the range of mild mental retardation. Tr. 613. She had pervasive cognitive deficits, and exhibited concrete thinking, impaired judgment, poor visual and auditory memory with evidence of proactive inhibition, limited vocabulary skills, and impaired visual perception, spatial orientation and nonverbal reasoning, planning, sequencing, and logical reasoning. Id. She also suffered from severe anxiety and depression with psychotic features. Id. Dr. Tinker expressed a concern that plaintiff was functionally illiterate. Tr. 614. He noted her history of repeated suicidal and self-mutilation behavior. Id.

As for her employability, he stated that she was moderately limited in her ability to remember locations and work-like procedures as she sometimes became disoriented and lost in familiar surroundings. Id. Her ability to understand, remember, and to carry out very short, simple, and detailed instructions was markedly limited, as was her ability to maintain attention and concentration for extended periods. Id. Her ability to adhere to a schedule was markedly limited, as was her ability to sustain an ordinary routine without special supervision. Id. Her ability to work in coordination with others was also markedly limited. Id.

Dr. Tinker also found plaintiff markedly limited in the following abilities: (1) to make simple work-related decisions; (2) to complete a normal work schedule and to work at a consistent pace; (3) to interact appropriately with the general public; (4) to ask questions or request assistance; (5) to accept instructions and

to respond appropriately to criticism from supervisors; (6) to get along with co-workers; (7) to maintain socially appropriate behavior; (8) to adhere to basic standards of neatness and cleanliness; (9) to respond to appropriate changes in the work setting; (10) to be aware of normal hazards and take appropriate precautions; (11) to travel in unfamiliar places or use public transportation; and (12) to set realistic goals or make independent plans. Tr. 614-15.

On December 13, 2002, plaintiff was evaluated by psychologist James Bryan, Ph.D. Tr. 684-98. Like Dr. Tinker, Dr. Bryan administered several tests to plaintiff in addition to interviewing her. Id. Dr. Bryan indicated that his evaluation was requested as a follow-up to Dr. Tinker's, upon request of the Disability Services Office medical review team because of questions regarding "the accuracy of previous diagnoses, particularly in terms of Ms. Gill's credibility in symptom reporting, and the possibility of her malingering." Tr. 685.

Dr. Bryan administered the Test of Memory Malingering (TOMM) to measure response validity. Tr. 691. He noted that plaintiff's scores were "consistent with, at best, lack of interest or effort, and more likely deliberate under-performance on this measure." Id. He stated that there was a high probability that low scores on other cognitive measures represent "motivated under-performance." Id. Dr. Bryan began the conclusion and recommendation section of his report by noting that "[n]o clear diagnostic conclusions can be drawn, given plaintiff's invalid engagement on intellectual and cognitive . . . " Tr. 692. The next page is almost entirely unreadable due to some type of printing error. Tr. 693. However,

it appears that Dr. Bryan may have noted a provisional diagnosis of malingering, but that some limitations persisted. Id.

On April 28, 2003, Family Nurse Practitioner Ijeoma Nwerem, wrote that plaintiff was currently a patient of Project Network, and was currently undergoing treatment with Nwerem for depression, anxiety, and bipolar disorder. Tr. 587. That same date, Kolokolo wrote a letter indicating that plaintiff had a mental health diagnosis of PTSD and depression NOS. Tr. 588. Kolokolo noted that plaintiff had been reevaluated by the "Psych RN" and recently started on new medication to help with keeping her mood balanced. Id. Kolokolo also reported that plaintiff demonstrated limited ability to deal with stress and recently told staff that she felt like hurting herself. Id. She was put on a "no self-harm contract." Id. Kolokolo noted plaintiff's limited coping skills and difficulty with self-soothing techniques and problem solving skills. Id. Due to her mental health issues, she had difficulty in finding housing, employment and in her ability to make sound decisions. Id.

On August 29, 2003, plaintiff was seen by someone at Cascadia because of an "urge to use," and irritability. Tr. 703. Although there are additional remarks written in the "presenting problem" section of the assessment, they are illegible. Id. The impression of the clinician, whose name is also illegible, was PTSD. Id. In a typewritten note dated that same day, Alison Noice, "QMHP" reported that plaintiff felt anxious, was experiencing an increase in agitation and restlessness, and was irritable and short-tempered. Tr. 701. Plaintiff also reported diminished sleep and appetite, as well as trouble concentrating. Id. Plaintiff was

prescribed two medications: Geodon and Seroquel[7]. Tr. 702.

On September 30, 2003, plaintiff was seen at the Providence Ambulatory Care & Education Center as a new patient and to establish a relationship with a primary care provider. Tr. 728. In the history and physical section, it is noted that plaintiff presented with severe depression, was currently homeless, and related a history of bipolar disorder, depression, and polysubstance abuse. Tr. 728. She brought an empty bottle of Seroquel. Id.

The medical chart suggests that both attending physician Dr. Pamela Bullock, M.D., and resident/student Karyn Ofa, D.O., examined plaintiff. Tr. 730. Their assessment was that plaintiff suffered from bipolar disorder, currently in a major depression, and possibly schizotypical. Id. Her Seroquel was refilled. Id. She met with a social services worker during the visit. Plaintiff did not want hospitalization and she agreed to a verbal no-harm contract. Id. She was given an antibiotic for a possible urinary tract infection and told to return in two days. Id.

Chart notes from Cascadia dated November 18, 2003, show that plaintiff complained of a depressed mood and a relapse on cocaine four days prior. Tr. 793. She was crying and tearful and requested hospitalization. Id. She was given more Geodon and Seroquel and was sent to the emergency department at Woodland Park Hospital for evaluation. Id.

On December 16, 2003, plaintiff went back to Cascadia

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[7] Both of these drugs are antipsychotic medications used to treat schizophrenia and bipolar disorder. www.drugs.com

requesting medication. Tr. 841. She explained that she had not presented to the Woodland Park emergency room the previous month, but had gone with her daughter to Seattle. Id. A medication management sheet from Cascadia indicates that the Geodon and Seroquel were renewed again on December 16, 2003. Tr. 794.

On May 25, 2004, plaintiff underwent a psychological evaluation by psychologist Frank P. Colistro, Ed.D. Tr. 798-800. Plaintiff was referred by Disabled Services to assist in determining whether she suffered from psychological problems constituting a substantial impairment of employability. Tr. 798. Dr. Colistro noted that Cascadia's December 16, 2003 progress notes showed that plaintiff was seen on that date and was described as having been clean and sober since November 14, 2003. Id. He also noted that she was placed on anti-depressant medication. Id.

Dr. Colistro stated that plaintiff reported taking the medication as prescribed by Cascadia, but running out three days prior to her evaluation with Dr. Colistro. Id. He noted that she appeared highly agitated and tearful throughout his contact with her, "expressing herself in a markedly rambling and tangential fashion." Tr. 799. She appeared to be attending to internal stimuli, and talked about being plagued by voices which command her to harm herself. Id. Her statements reflected a high degree of apparently delusional suspiciousness and mistrustfulness. Id. She reported that she had not relapsed into drug or alcohol use, but she admitted her past substance abuse problems. Id.

Dr. Colistro administered the Weschler Adult Intelligence Scale-III (WAIS-III) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Id. Results were not reported because

plaintiff was so "obviously agitated and inattentive" that results could not possibly be valid. Id.

Dr. Colistro determined that plaintiff's diagnoses were (1) depression, recurrent, severe with psychotic features; (2) panic disorder without agoraphobia; (3) polysubstance dependence/abuse, by history, reported in full remission; and (4) personality disorder with dependent and inadequate features. Tr. 800.

Dr. Colistro stated that plaintiff presented with signs and symptoms of major affective, anxiety-related and characterologic problems which exerted a "profoundly negative impact on functioning in all areas." Id. He noted that her depression was reflected in symptoms including anergia, anhedonia, onset and middle insomnia, feelings of guilt and worthlessness, psychomotor agitation, difficulty concentrating, history of suicidality, and paranoid delusions and auditory hallucinations. Id.

Her anxiety-related disorder was reflected in "recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror, and sense of impending doom occurring on the average of at least one a week." Id. He noted that she previously had been diagnosed as suffering from PTSD. Id. He further noted that her personality disorder was reflected in seclusiveness, pathologically inappropriate suspiciousness, and persistent disturbance of mood and affect. Id.

Dr. Colistro opined that the combined impact of plaintiff's condition resulted in marked restriction of activities of daily living and marked difficulties in maintaining social functioning. Id. He noted that deficiencies of concentration, persistence or pace resulting in a failure to complete tasks in a timely manner in

work settings and elsewhere, were occurring constantly, as were "episodes of deterioration or decompensation in work or worklike settings which have caused her to withdraw from these and to experience exacerbation of signs and symptoms of her conditions, especially anxiety and depression." Id. He indicated that her conditions had lasted for at least one year and would "persist for that long and beyond." Id. He further indicated that she was not capable of managing her own funds. Id.

In a "Rating of Impairment Severity Report," Dr. Colistro found plaintiff markedly restricted in the following categories: (1) activities of daily living; (2) social functioning; and (3) concentration, persistence, or pace. Tr. 801. As support for his ratings, he noted that plaintiff was a chronically mentally ill patient, who was severely depressed, lived in the streets, with her state caseworker her only support. Id. He also noted that she reported avoiding social interactions with all others except her caseworker. Id. He further indicated that he observed her on that date to be so distraught and agitated that she was unable to participate in a mental status examination, was marginally able to provide an adequate history, and was unable to generate valid psychologic test results. Id.

In this report, Dr. Colistro also noted that plaintiff had experienced four or more episodes of decompensation over a twelve-month period prior to assessment. Tr. 801-02. He based this on plaintiff's report of a lifelong history of major decompensation in work settings, even when the work setting is low stress. Tr. 802.

On August 3, 2004, plaintiff was seen by staff at Cascadia. Tr. 862. According to the Adult Behavioral Assessment of that

date, signed by Amy Daviau, M.S.W., plaintiff reported not having taken medications in six months because she lost her health coverage and stopped receiving services. Tr. 863. Plaintiff was homeless at the time, and reported being homeless for more than one year. Id. Plaintiff reported that she had a history of bipolar disorder, PTSD, and schizophrenia. Id. She also reported feeling helpless and having problems with sleep. Id. She had difficulty answering questions regarding her current risk of suicide. Id. She presented with motor abnormalities including body rocking and facial grimaces. Id. She was not a good historian. Id. She endorsed hearing voices, but did not give details about content or frequency. Id.

In the physical health section, current medical issues of Hepatitis-C, history of migraines, arthritis, and carpal tunnel, were noted. Tr. 865. Plaintiff also remarked that she did not get enough to eat. Id.

Daviau's diagnostic impressions were bipolar disorder, PTSD, schizophrenia, rule out alcohol abuse or dependence, history of migraines, Hepatitis-C, and arthritis. Tr. 866. She also noted plaintiff's inadequate finances, homelessness, and inadequate support system. Id. She assessed plaintiff as having a GAF of 43. Id.

In an August 3, 2004 Treatment Plan, Daviau states that plaintiff will be given "bridge" medications to last until she could be seen for a full medication evaluation. Tr. 868. Plaintiff was to take the medication as prescribed and attend monthly "LMP" meetings. Id. Plaintiff was to be evaluated for drug and alcohol use and follow suggested treatment. Id. She was

to be referred to a housing specialist. Id.

On September 10, 2004, plaintiff was given a psychiatric evaluation by Cascadia's Jack Pladel, a psychiatric mental health nurse practitioner. Tr. 855-58. Pladel described plaintiff as clean and well groomed, but obviously dysphoric and depressed. Tr. 856. Plaintiff was tearful at times. Id. Her affect was "full range" and there was severe poverty of content and paucity of speech to her narrative. Id. There was poor, if any, eye contact. Id. She rocked back and forth in a chair and had a fair amount of anxiety. Id. Her speech was of low intonation and low volume and was difficult to track at times. Id. She looked anxious and upset. Id. Recent and remote memory was not tested. Id.

Pladel's initial diagnostic impressions were (1) alcohol dependence in early sustained remission; (2) cocaine dependence in sustained remission, (3) cannabis dependence in sustained remission; (4) provisional - PTSD, chronic; (5) rule out major depressive disorder, recurrent with psychotic features; (6) rule out mood disorder nos; (7) history of migraines; (8) Hepatitis-C; (9) arthritis; and (10) chronic neck and back pain. Id. He assessed her current GAF as 30. Id.

Pladel changed some of plaintiff's medications, had plaintiff agree to a no-harm contract, and scheduled her to return in three weeks. Tr. 858.

It does not appear that plaintiff returned to see Pladel in late September or early October. She apparently called Cascadia on November 8, 2004, expressing a desire to be engaged in more services. Tr. 853. Cascadia staff spoke to her about her needs and requested that she come to the "HARTS" group. Id.

On January 14, 2005, plaintiff returned to Cascadia. Tr. 851. Her engagement in services was discussed and she was given a group schedule and a time for "housing walk in." Id. Plaintiff was then seen by Pladel. Tr. 852. He noted that she reported that she had been released two to three months earlier from the King County jail in Seattle, and that she had not been on medications while in jail.[8] Id.

She appeared ill, with a productive cough, malaise, sniffs, and rhinitis. Id. Pladel assessed her as currently having an upper respiratory infection of pneumonia or bronchitis. Id. He planed on having her resume her medications and gave her samples. Id. He instructed her to return in five days to pick up more. Id.

II. Plaintiff's Testimony at 2005 Hearing

The initial line of questioning at this hearing concerned plaintiff's work history. Plaintiff testified that she had no memory of performing work in 2000 which generated approximately $5,200 in earnings that year. Tr. 927, 929. She also does not remember jobs producing approximately $1,000 in the couple of years after that. Id. She has no memory of doing any work at all in the four or five years before the hearing. Id.

Plaintiff testified that she was unsure if she currently had health insurance. Tr. 930. She explained that she had not received mail and that when she went to Cascadia to try to get medications and sign up for a counselor, they told her she did not have any medical coverage. Id. Plaintiff testified that Aging and

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[8] The record does not reveal the reason for this incarceration or its duration.

Disability Services thought she had coverage, but Cascadia did not. Tr. 931.

Plaintiff stated she was homeless and had been for over a year. Id. She stayed in abandoned cars and houses. Id. Before that, she lived on and off with her abusive ex-husband. Tr. 932. She received her mail at her mother's house, but she did not stay with her mother because of plaintiff's "issues." Id. She goes months without talking to or seeing her mother. Id.

Between the time of the first hearing in October 2003, and the hearing in September 2005, plaintiff stated that she had received medications from Cascadia. Tr. 933.

Plaintiff explained that in the past, the medications she had taken to address her mental illness included Geodon, Seroquel, Zoloft, trazodone, and diazepam. Tr. 931. At the time of the hearing, she had not received medications in the last four or five months because she had no money to buy them. Tr. 934.

She testified she was still hearing voices once in awhile. Id. She spent her days sitting in cars or sitting in an abandoned house. Tr. 935. When hungry, she begs for food or sometimes steals. Id.

Plaintiff stated that she last used alcohol two days before the hearing. Id. She drank an eight or twelve ounce can of beer. Id. Prior to that, it had been about four months since she had alcohol. Tr. 936. It had been about seven months since she last used cocaine. Id.

In regard to her Hepatitis-C, plaintiff stated that she was constantly tired and fatigued and this continued to worsen. Tr. 937. She also weighed sixty to seventy pounds less than she had at

the 2003 hearing because she does not eat very often. Id.

III. Medical Expert Testimony at 2005 Hearing

Psychologist Dr. Sally Clayton testified at the hearing. Tr. 938-55. Clayton initially diagnosed plaintiff with mild mental retardation, chronic PTSD, and personality disorder nos. Tr. 939-41. Dr. Clayton assessed plaintiff as having marked impairment in activities of daily living, social functioning, and concentration, persistence, and pace. Tr. 942. This opinion was with consideration of plaintiff's substance abuse. Id. Dr. Clayton also opined that there was insufficient evidence to assess plaintiff's episodes of decompensation. Id.

Without substance abuse, Dr. Clayton opined that plaintiff would be mildly impaired in her activities of daily living, moderately impaired in social functioning, and markedly impaired in concentration, persistence, and pace. Tr. 943. This assessment, however, was based on her assumption that medication to treat plaintiff's PTSD was available to her. Id. Without such medication, Dr. Clayton considered plaintiff to be markedly impaired in social functioning. Id.

Upon questioning by the ALJ, and a review of the 1999 psychological evaluation by Dr. Jenkins, Dr. Clayton reconsidered her diagnoses and retracted her mild mental retardation diagnosis. Tr. 947. Dr. Clayton explained that plaintiff probably has a learning disability in math at least, and that one could "generously say the borderline range of intellectual functioning." Id. However, when the ALJ then immediately asked Dr. Clayton directly if she would drop the diagnosis of borderline IQ that she just assessed, Dr. Clayton responded "yes," which contradicts the

statement she had just made. Id.

With this, Dr. Clayton then revised her impairment assessment and stated that without substance abuse, she would consider plaintiff to have a moderate impairment in concentration, persistence, and pace. Id.

IV. Vocational Expert Testimony at 2005 Hearing

Vocational Expert (VE) Patricia Ayerza testified at the hearing. Tr. 956-59. The ALJ presented Ayerza with the following hypothetical: a worker with the same educational and vocational background as plaintiff, limited to simple, routine, repetitive work, no exposure to any hazardous conditions, and limited to light to medium levels of exertion. Tr. 956. Additional limitations were occasional use of ropes, ladders or scaffolds, occasional crawling or reaching, no interaction with the public, and occasional co-worker interaction. Id. The ALJ also added that deficiencies of concentration, persistence, and pace would interfere with the completion of tasks in a timely manner up to one-third of the workday. Tr. 957.

In response to this hypothetical, the VE testified that there were no jobs in the local or national economy that this hypothetical worker could sustain on a competitive basis. Id.

In response to questions by plaintiff's counsel, the VE testified that missing work a couple of days each month on a fairly consistent basis due to anxiety or paranoia would also preclude competitive employment. Id.

THE ALJ'S 2005 DECISION

The ALJ found that plaintiff had not engaged in any substantial gainful activity at any time since her protective

filing date of December 10, 2001. Tr. 111. He then determined that she suffers from severe impairments of degenerative disc disease, Hepatitis-C, anxiety-related disorder, personality disorder, and substance addiction disorder, in partial remission. Id.

Later, the ALJ elaborated on plaintiff's severe impairments and explained that having considered listed impairments 1.04 (disorders of the spine), 5.05 (Hepatitis-C), 12.05 (mental retardation), 12.06 (anxiety-related disorders), and 12.08 (personality disorders), absent drug or alcohol abuse, claimant had medically determinable impairments of mild degenerative disc disease of the cervical-lumbar spine, Hepatitis-C, mild mental retardation, anxiety/posttraumatic stress disorder, and a personality disorder. Tr. 117. While the ALJ found the impairments to be collectively severe, he also found that they did not meet or medically equal a listed impairment. Id.

Next, the ALJ considered plaintiff's residual functional capacity (RFC). The ALJ concluded that plaintiff had the physical capacity for medium level exertional work, plus postural, manipulative, and vocational non-exertional limitations. Tr. 119. First, he found that she could lift and carry up to twenty-five pounds frequently and up to fifty-pounds occasionally. Id. Next, he found she could sit occasionally for two hours (cumulatively, not continuously), in an eight-hour workday with normal breaks. Id. She could also perform prolonged standing and walking for six hours (cumulatively, not continuously), in an eight-hour workday with normal breaks. Id. Her push/pull exertional capacities, in her upper and lower extremities, are limited to those weight levels

that she can lift and carry. Id.

The ALJ further found that plaintiff can climb stairs and ramps but was limited to no more than occasional climbing of ropes, ladders, and scaffolding, and no more than occasional crawling. Id. She was also limited to no more than occasional reaching in all directions. Id.

Finally, the ALJ concluded that absent drug and alcohol abuse, plaintiff's non-exertional limitations restricted her to no more than simple, repetitive, routine work, with no public contact and only occasional contact with co-workers. Id. He further noted that when plaintiff has no access to medications, she has an additional limitation precluding her from basic work activities. Id. He explained, however, that he did not find evidence that plaintiff would be deprived of medications for any prolonged period of time, except for willful non-compliance with treatment or medication requirements. Id.

The ALJ next determined if there was other work, existing in significant numbers in the regional and national economy, that plaintiff could perform. Tr. 120. Based upon testimony from the VE at the first hearing in October 2003, the ALJ concluded that she could perform the jobs of janitor and laundry worker. Id. Accordingly, he concluded that plaintiff was not disabled. Id.

STANDARD OF REVIEW & SEQUENTIAL EVALUATION

A claimant is disabled if unable to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. § 423(d)(1)(A). Disability claims are evaluated according

to a five-step procedure. Baxter v. Sullivan, 923 F.2d 1391, 1395 (9th Cir. 1991). The claimant bears the burden of proving disability. Swenson v. Sullivan, 876 F.2d 683, 687 (9th Cir. 1989). First, the Commissioner determines whether a claimant is engaged in "substantial gainful activity." If so, the claimant is not disabled. Bowen v. Yuckert, 482 U.S. 137, 140 (1987); 20 C.F.R. §§ 404.1520(b), 416.920(b). In step two, the Commissioner determines whether the claimant has a "medically severe impairment or combination of impairments." Yuckert, 482 U.S. at 140-41; see 20 C.F.R. §§ 404.1520(c), 416.920(c). If not, the claimant is not disabled.

In step three, the Commissioner determines whether the impairment meets or equals "one of a number of listed impairments that the [Commissioner] acknowledges are so severe as to preclude substantial gainful activity." Yuckert, 482 U.S. at 141; see 20 C.F.R. §§ 404.1520(d), 416.920(d). If so, the claimant is conclusively presumed disabled; if not, the Commissioner proceeds to step four. Yuckert, 482 U.S. at 141.

In step four the Commissioner determines whether the claimant can still perform "past relevant work." 20 C.F.R. §§ 404.1520(e), 416.920(e). If the claimant can, he is not disabled. If he cannot perform past relevant work, the burden shifts to the Commissioner. In step five, the Commissioner must establish that the claimant can perform other work. Yuckert, 482 U.S. at 141-42; see 20 C.F.R. §§ 404.1520(e) & (f), 416.920(e) & (f). If the Commissioner meets its burden and proves that the claimant is able to perform other work which exists in the national economy, he is not disabled. 20 C.F.R. §§ 404.1566, 416.966.

The court may set aside the Commissioner's denial of benefits only when the Commissioner's findings are based on legal error or are not supported by substantial evidence in the record as a whole. Baxter, 923 F.2d at 1394. Substantial evidence means "more than a mere scintilla," but "less than a preponderance." Id. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Id.

DISCUSSION

Plaintiff makes several arguments in support of her contention that the ALJ's non-disability determination is erroneous. The arguments fall into seven categories: (1) erroneous vocational evidence; (2) failure to consider GAF scores; (3) error in considering medical non-compliance; (4) improper legal standard; (5) substance abuse materiality analysis; (6) improper rejection of medical evidence; and (7) improper rejection of plaintiff's testimony.

Because I find some of the arguments dispositive, I do not address them all.

I. Medical Non-Compliance

The ALJ first mentioned "non-compliance" when rejecting Pladel's GAF score of 30. Tr. 115. There, the ALJ explained that he gave Pladel's diagnosis and GAF score no weight because of plaintiff's infrequent visits to Cascadia, "her admitted non-compliance in taking her medications," and Pladel's assessment not being co-signed or supervised by a clinical psychologist or psychiatrist. Id.

Later, while still discussing the severity of plaintiff's impairments, the ALJ referred to plaintiff's September 2005

testimony that she had been without funds or medical insurance coverage to obtain her mental health medications "for about the last four months." Tr. 117. The ALJ explained that an inability to obtain mental health medication would "adversely impact [plaintiff's] capacity for concentration, persistence and pace, to a 'marked' degree." Id. However, the ALJ found that plaintiff's inability to obtain medications had existed for only four months, eight months shy of the durational requirement of twelve continuous months. Id. Additionally, the ALJ stated that plaintiff had become "well-versed in being able to obtain at least samples of her medication as needed" through Cascadia and most likely through other sources as well, including the Oregon Health Plan, the County Mental Health Clinic, and general assistance." Id. Thus, the ALJ concluded that the potential for plaintiff to involuntarily be without medications for twelve continuous months was not likely. Id.

In the discussion of her RFC, the ALJ stated that when plaintiff has no access to medications, she is precluded from basic work activities. Tr. 119. Again, however, he noted that the record did not support a finding that plaintiff would be deprived of her medications for a prolonged period of time, such as for twelve continuous months, except for willful non-compliance in following through with treatment or medication requirements. Id.

As I understand the ALJ's decision, he found that without access to her medications, plaintiff is disabled because she is precluded from basic work activities. However, the ALJ concluded that plaintiff was not disabled because (1) access to her medications was due to her willful non-compliance; and (2) any

involuntary inability to obtain medications did not meet the twelve-month durational requirement because although plaintiff did not appear to have funds or health insurance, her involuntary inability to obtain medications had lasted only four months and plaintiff was "well versed" in obtaining her medications from other sources.

Plaintiff argues that (1) the ALJ erred in concluding that her failure to take prescription medication is due to willful non-compliance; (2) it is unreasonable to conclude that plaintiff's erratic medication history is willful non-compliance given the differences between mental and physical impairments; (3) the ALJ offers no evidence to support his speculation that medication removes plaintiff's mental and psychological disorders; and (4) the ALJ failed to comply with Social Security Ruling 82-59.

I agree with plaintiff that the ALJ erred in concluding that substantial evidence shows that her failure to take her prescription mental health medications is due to willful non-compliance. As noted above, the ALJ referred to plaintiff's "admitted non-compliance in taking her medications[.]" Tr. 115. But, I fail to see any discussion by the ALJ of the evidence supporting this conclusion.

Before making this statement, the ALJ referred to plaintiff's alleged intermittent visits to Cascadia in late 2003 to early 2005 in which she asked for medications. For a mentally ill individual with no health insurance and no funds, intermittent visits to obtain medications, without more, is not substantial evidence of willful non-compliance in taking medications.

Moreover, the ALJ mistakenly indicates that plaintiff went to

Cascadia only three times in twenty-six months. Tr. 115. The record shows that plaintiff received treatment from Cascadia on at least six occasions in a seventeen-month period. Tr. 703 (psychiatric assessment performed on August 29, 2003)[9]; Tr. 793 (progress note from Cascadia dated Nov. 18, 2003); Tr. 794, 841 (progress note and medication record from Cascadia for December 15, 2003); Tr. 862 (progress note from Cascadia dated Aug. 3, 2004); Tr. 855-58 (psychiatric evaluation by Pladel at Cascadia dated Sept. 10, 2004); Tr. 851-52 (progress notes dated January 14, 2005).

Furthermore, caselaw supports plaintiff's position that non-compliance with mental health treatment should be viewed differently than non-compliance with recommended treatment for physical ailments. As the Sixth Circuit explained, "[a]ppellant may have failed to seek psychiatric treatment for his mental condition, but it is a questionable practice to chastise one with a mental impairment for the exercise of poor judgment in seeking rehabilitation." Blankenship v. Bowen, 874 F.2d 1116, 1124 (6th Cir. 1989).

Moreover, there is no basis in the record for the ALJ to find that plaintiff can regularly obtain her required medications from various sources such as charity (samples from Cascadia), the County, or general assistance. As plaintiff testified, at the time

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[9] While page 703 does not expressly state that it is a record generated by Cascadia, other evidence in the record indicates that it is a psychiatric assessment performed by Cascadia staff. Tr. 700 (indicating record on page 703 is from Cascadia); Tr. 5 (listing pages 699-703 as medical records from Cascadia).

of the September 2005 hearing, it was unclear if she had any health insurance. Tr. 930-31. There does not appear to be any affirmative evidence in the record demonstrating that she had health insurance or was enrolled in the Oregon Health Plan at that time. Generally, the record contains scant evidence regarding her insured status.

The ALJ offers no basis in the record for his conclusion that a claimant with severe impairments such as plaintiff's and with no health insurance or funds, will be able to regularly obtain her required psychiatric medications from a variety of diverse charitable or public sources. Social Security Ruling (SSR) 82-59 (available at 1982 WL 31384), indicates that before relying on free community resources as an available source of treatment, "[c]ontacts with such resources and the claimant's financial circumstances must be documented." SSR 82-59. This seems particularly appropriate in the case of mental impairment as opposed to physical impairment. Here, other than occasional receipt of samples from Cascadia, the record does not contain any information about the other resources named by the ALJ. Thus, his conclusion that procuring sample medications from these resources is a viable treatment source is speculative and is not supported by substantial evidence in the record.

Without substantial evidence in the record to support his finding that plaintiff is willfully non-compliant with her medications, and without substantial evidence in the record to support his finding that the twelve-month durational impairment is not met because plaintiff is able to obtain samples from various community resources, the ALJ's finding is that plaintiff is

disabled. With this, the case should be remanded for a determination of benefits.

II. Rejection of Medical Evidence

Plaintiff contends that the ALJ erred in rejecting the opinions of (1) examining psychologist Dr. Tinker; (2) examining psychologist Dr. Colistro; and (3) medical expert Dr. Clayton.

A. Dr. Tinker

The ALJ noted that in October 2002, Dr. Tinker assessed plaintiff with diagnoses of bipolar disorder, PTSD, cognitive disorder, mild mental retardation, and personality disorder with alcohol and cocaine dependence. Tr. 113. Later, however, the ALJ stated that he gave Dr. Tinker's opinion little weight because Dr. Tinker ignored plaintiff's drug and alcohol history, her relapses, and the effects her use had on her overall mental functioning. Tr. 118. The ALJ also stated that "Dr. Tinker fails to give any rationale for his opinion and fails to state any objective evidence to support such an opinion. He fails to administer any psychological testing, such as the TOMM or MMPI to substantiate the claimant's subjective complaints[.]" Tr. 119.

> To reject an uncontradicted opinion of a treating or examining doctor, an ALJ must state clear and convincing reasons that are supported by substantial evidence. . . . If a treating or examining doctor's opinion is contradicted by another doctor's opinion, an ALJ may only reject it by providing specific and legitimate reasons that are supported by substantial evidence.

Bayliss v. Barnhart, 427 F.3d 1211, 1216 (9th Cir. 2005) (citation omitted).

The ALJ's first reason for rejecting Dr. Tinker's opinion cannot be squared with the ALJ's own determination that plaintiff's

substance abuse is not material in the disability determination.[10]

Next, Dr. Tinker's report reveals that he completed a fairly extensive mental status examination over the course of two days. Tr. 607-10. Additionally, Dr. Tinker administered the following tests: (1) Shipley Institute of Living Scale, (2) WAIS-III, (3) Reitan-Indiana Aphasia Screening Tests, (4) Trial Making Test, (5) Hooper Visual Organization Test, (6) Bender Visual-Motor Gestalt Test, (7) Benton Revised Visual Retention Test, (8) Complex Figure Test, (9) Auditory-Verbal Learning Test, (10) Wechsler Memory Scale-Revised, (11) Wide Range Achievement Test-III, (12) Millon Clinical Multiaxial Inventory-III, (13) Beck Depression Inventory-II, and (14) Pain Apperception Test. Tr. 610-13.

The ALJ fails to adequately explain why the absence of two particular tests, the TOMM and the MMPI, would substantiate Dr. Tinker's conclusions while the thirteen different tests he did administer, do not. Without a thorough discussion of this issue, the argument put forth by the ALJ that Dr. Tinker's opinions have little weight because he failed to administer psychological testing or offer objective evidence in support of his opinion, is not supported by clear and convincing evidence or specific and legitimate reasons.

Dr. Tinker offers numerous conclusions regarding plaintiff's impairments and her functional capacity. Tr. 613-16. Without

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[10] The ALJ erred as well because Dr. Tinker (1) noted plaintiff's history of substance abuse in the first sentence of his report; Tr. 603; (2) gave details of her substance abuse in the background section of the report; Tr. 604; (3) noted her arrests for possession of a controlled substance; Tr. 605; and (4) noted her alcohol and cocaine dependence in his diagnostic impressions. Tr. 615.

identifying which specific opinions, the ALJ states that Dr. Tinker's "opinions" are not supported by Dr. Jenkins, Dr. Bryan, or Dr. Colistro, and further, that they are not endorsed by medical experts Dr. Crossen or Dr. Clayton.

Dr. Jenkins believed it likely that plaintiff had a learning disability or cognitive disorder and indicated that plaintiff's intellectual functioning was borderline. Tr. 355, 356. This is not obviously inconsistent with Dr. Tinker's conclusion that plaintiff has mild mental retardation. Tr. 615.

Dr. Bryan opined that based on her WAIS-III results, plaintiff's intellectual capacity was in the extremely low intellectual range, with a full scale IQ of 63. Tr. 691. This was the same score reported by Dr. Tinker. Tr. 610.

Dr. Colistro found that plaintiff was markedly limited in her activities of daily living and in maintaining social functioning, and had a constant deficiency of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner. Tr. 800. Dr. Tinker concluded that plaintiff was severely restricted in her daily living skills, was markedly limited in her ability to maintain socially appropriate behavior, and had severe deficiencies of concentration, persistence, or pace that resulted in a failure to complete tasks in a timely manner. Tr. 614.

These examples demonstrate that substantial evidence does not support the ALJ's conclusion that Dr. Tinker's opinions are not supported by those of Dr. Jenkins, Dr. Bryan, or Dr. Colistro.

As for the two medical experts, Dr. Clayton discussed Dr. Tinker's WAIS-III scoring and whether it was valid. Dr. Clayton started by stating that one of plaintiff's impairments was mild

mental retardation, based on the fact that plaintiff had taken "the IQ test" on two different occasions and got pretty similar scores, referring to the scores obtained by Dr. Tinker and Dr. Bryan. Tr. 939. The ALJ then asked if both were valid. Id. Dr. Clayton responded that Dr. Tinker's assessment did not discuss validity whereas Dr. Bryan indicated much of the testing was not interpretable. Id. She then noted that as to the WAIS-III, however, Dr. Bryan stated that it represented a valid summary of plaintiff's overall performance. Id.

The ALJ pressed Dr. Clayton further and asked if Dr. Bryan indicated that there was poor performance on testing. Id. Dr. Clayton responded that Dr. Bryan had administered the TOMM and said that at best, there was a lack of interest or effort and a high probability that plaintiff was motivated to underperform. Tr. 939-40. Still, Dr. Clayton reiterated, on the WAIS-III, Dr. Bryan commented that that particular test was a valid summary of her performance. Tr. 940; see also Tr. 691 (Dr. Bryan's report noting that a two-point verbal performance IQ difference was not statistically significant such that the full scale IQ represented a valid summary of her overall performance). Dr. Clayton also reiterated that Dr. Tinker did not indicate that the WAIS-III test her administered was invalid. Tr. 941.

Later in the hearing, the ALJ referred to Dr. Jenkins's 1999 evaluation and plaintiff's verbal IQ score of 84 at that time. Tr. 945; see also Tr. 355 (test scores recited in Dr. Jenkins's

report).[11] Dr. Clayton indicated that although she had reviewed Dr. Jenkins's report, she had neglected to include it in her summary and upon examining it again, she might have to omit mild mental retardation as a diagnosis. Tr. 946. However, she agreed with the ALJ that the performance and full scale IQ scores were in the mid-70s and noted that Dr. Jenkins herself reported that plaintiff's scores fell within a borderline intellectual functioning range. Tr. 947. Dr. Clayton then indicated that while she was withdrawing her finding of mild mental retardation, she "could generously say [that plaintiff fell in] the borderline range of intellectual functioning." Id. The ALJ then asked her if she would drop the diagnosis of "borderline IQ," and Dr. Clayton responded that she would. This contradicts the statement she had just made.

In my reading of the testimony, Dr. Clayton's discussion of Dr. Tinker's assessment, her repeated statements that Dr. Tinker made no reference to the WAIS-III score being invalid, and her interpretation of Dr. Bryan's report that while other tests he administered suggested plaintiff may have been exaggerating, the WAIS-III score was nonetheless a valid summary, are supportive of Dr. Tinker's conclusion of mild mental retardation.

Moreover, as discussed further below, Dr. Clayton's opinions regarding plaintiff's functional limitations are similar to Dr. Tinker's in some aspects. She concluded that without medication, plaintiff's social functioning was markedly impaired. Tr. 943.

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[11] Curiously, neither the ALJ nor Dr. Clayton noted that Dr. Jenkins administered the WAIS-Revised (WAIS-R), not the WAIS-III. Thus, it is unclear from the record whether the scores from Dr. Jenkins's testing are even comparable to the scores from Dr. Tinker's or Dr. Bryan's testing.

She also concluded that with a diagnosis of mild mental retardation, plaintiff had marked impairment in concentration, persistence, and pace, even absent drug and alcohol use. Tr. 943. These findings are consistent with Dr. Tinker's findings. Thus, the evidence does not support the ALJ's conclusion that Dr. Clayton did not endorse Dr. Tinker's opinions.

Medical expert Dr. Crossen, who testified at the October 30, 2003 hearing, discounted Dr. Tinker's assessment because there was no assessment of the validity of plaintiff's self-report. Tr. 914. He stated that Dr. Tinker "comes up with a mild mental retardation diagnosis." Id. He opined that Dr. Tinker's evaluation was an "unpenetrating psychological assessment." Tr. 915. He noted that the extremely low scores are "red flags for flat out malingering." Id.

The problem with relying on Dr. Crossen's testimony as the basis for rejecting Dr. Tinker's testimony is that "[t]he opinion of a non-examining medical expert, with nothing more, is not substantial evidence sufficient to support a denial where the record contains conflicting observations, opinions and conclusions of an examining physician." Stark v. Shalala, 886 F. Supp. 733, 735 (D. Or. 1995); see also Lester v. Chater, 81 F.3d 821, 831 (9th Cir. 1995) ("The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician or a treating physician.").

Ninth Circuit law recognizes that a non-examining physician's opinion may constitute substantial evidence if it is consistent with other independent evidence in the record. Thomas v. Barnhart,

278 F.3d 947, 957 (9th Cir. 2002). Here, the ALJ does not identify which of the many of Dr. Tinker's opinions he found unsupported by the medical experts. As seen from the discussion above, some of Dr. Tinker's opinions are supported by other examining psychologists and thus, other independent evidence in the record is consistent with Dr. Tinker's assessment, not the medical expert's.

As to Dr. Crossen's testimony, the only evidence in the record that could provide support for a finding of malingering is a provisional diagnosis by Dr. Bryan. Dr. Bryan noted that plaintiff's TOMM test results showed at best, lack of interest or effort and more likely deliberate under-performance. Tr. 691. He also stated that there was a high probability that low scores on other cognitive measures represented motivated under-performance. Id. In discussing her MMPI-2 profile, Dr. Bryan noted that her responses indicated extreme over-reporting and exaggeration of her symptomatology. Tr. 692.

Dr. Bryan's conclusions are practically undecipherable due to an obvious photocopying error. Tr. 693. The likely references to malingering, however, are followed by the word "provisionally." Id. Also, Dr. Bryan's conclusions do not rule out Dr. Bryan nonetheless finding that plaintiff is suffering from various impairments or having certain functional limitations, notwithstanding his concerns about her overreporting and exaggeration of her symptoms. The record in its present state, with equivocal conclusions from Dr. Bryan, does not provide sufficient support for Dr. Crossen's opinion so as to constitute substantial evidence for the rejection of Dr. Tinker's opinion.

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B. Dr. Colistro

The ALJ gave Dr. Colistro's May 25, 2004 assessment no weight. Tr. 115. The ALJ explained that Dr. Colistro's assessment of marked limitations in (1) activities of daily living, (2) socialization, and (3) concentration, persistence, and pace, were not supported by "evidence anywhere in the record." Id. This conclusion by the ALJ is not supported by the record. Dr. Tinker also assessed plaintiff with several marked limitations. Tr. 614-15. Dr. Clayton did as well. Tr. 942-43. Additionally, some of the GAF scores suggest marked limitations. E.g., Tr. 840 (GAF 50 assessed by social worker Cynthia Eckersey on March 18, 2002, which, according to the Diagnostic & Statistical Manual of Mental Disorders, Revised 34 (4th ed. 2000) ("DSM-IV-R"), indicates serious symptoms (suicidal ideation, severe obsessional rituals, frequent shoplifting), or any serious impairment in social, occupational, or school functioning (no friends, unable to keep a job); Tr. 617 (GAF of 38 by Kolokolo on August 20, 2002 indicating, under the DSM-IV-R "[s]ome impairment in reality testing or communication (e.g. speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school)"; Tr. 616 (GAF of 21 assessed by Dr. Tinker on October 6, 2002, indicating, under the DSM-IV-R, behavior considerably influenced by delusions or hallucinations or serious impairment in communication or judgment (sometimes incoherent, acts grossly inappropriately, suicidal preoccupation),

or an inability to function in almost all areas (stays in bed all day; no job, home, or friends).

The ALJ further explained that Dr. Colistro himself noted that the objective testing results were invalid. Id. Dr. Colistro's assessment was based on his review of plaintiff's records from Cascadia and his mental status exam of plaintiff. Tr. 798-800. Dr. Colistro explained that while he administered the WAIS-III and the MMPI-2, the test results were not valid because on the day he evaluated plaintiff and administered the tests, plaintiff was so obviously agitated and inattentive that the results could not be valid.

The fact that the test results from these two tests were invalid because of plaintiff's mental and emotional state on the day they were administered is not a basis for rejecting Dr. Colistro's report when he did not base his assessment on those test results. The inability of a claimant due to her mental disabilities to provide valid objective test results on a given day, does not, in and of itself, discredit Dr. Colistro's assessment. This assessment is also supported by Dr. Colistro's review of the treating provider's records.

The ALJ's additional reasoning regarding his rejection of Dr. Colistro's assessment is a bit unclear. Tr. 115. The ALJ appears to suggest that Dr. Colistro's reliance on the notes from Cascadia are not reliable because those notes reflect only walk-in visits three times over a twenty-six-month period: November 2003, September 2004, and January 2005. Id.

But, as described above, the record shows that plaintiff received treatment from Cascadia on at least six occasions in a

seventeen month period. Tr. 703, 793, 794, 841, 862, 851-52.[12] Thus, the record does not support the ALJ's suggestion that Cascadia's records are unworthy of reliance because plaintiff's treatment there was sporadic.

Next, the ALJ indicates that Dr. Colistro's reliance on plaintiff's self-reports is inappropriate because plaintiff's report to Dr. Colistro of taking her medications regularly is, according to the ALJ, an "indisputable fabrication" as plaintiff "repeatedly returns to Cascadia for re-initiation of her medications after extensively long periods of going without medications." Tr. 115.

Dr. Colistro reported on May 25, 2004, that plaintiff told him that "[s]he has been taking her medication as prescribed by Cascadia regularly, but says that she ran out three days ago." Tr. 798. The record shows that plaintiff obtained medications from Cascadia in August 2003, November 2003, and December 2003. Tr. 794. The first of these medication dispensations indicates that plaintiff received 30-60 days of medications. Id. The other two dispensations do not indicate the number of pills prescribed. Thus, the record does not reveal how many days or months of medications plaintiff received in December 2003. There is also no

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[12] Dr. Colistro's assessment is dated May 2004. It is unclear why the ALJ recited the Cascadia treatment dates of September 2004 and January 2005 when they obviously post-date Dr. Colistro's assessment. However, since the ALJ saw fit to note the post-assessment dates, I do as well.

Additionally, when records of Network Behavioral Healthcare are included as part of Cascadia Behavioral Healthcare, the record indicates that plaintiff was seen in January, March, and May of 2002 as well. Tr. 592-93, 596-97, 598, 601-02, 683.

way to tell if she received medications from other sources as the ALJ suggests she is adept at doing. As a result, Cascadia's records, and the record generally, do not provide substantial evidence for a finding that plaintiff's report regarding her regular taking of medications prescribed by Cascadia, was untrue.[13]

Finally, the ALJ rejected Dr. Colistro's assessment that plaintiff had multiple decompensations in work or work-like activities because, the ALJ noted, plaintiff has no past relevant work. Tr. 115. The ALJ himself, however, stated four pages earlier, that plaintiff had past relevant work as a childcare attendant. Tr. 111. The ALJ's basis for rejecting Dr. Colistro's assessment regarding decompensations is contradicted by the ALJ's own decision.

Additionally, plaintiff reported to Dr. Colistro that she had no significant work history, but that she had worked at McDonald's, an anodizing company, and doing in-home childcare, without success due to increased depression, agitation, panic and confusion. Tr. 799. She specifically noted that interpersonal problems had triggered episodes of emotional decompensation in those situations. Thus, there was evidence, by plaintiff's self-report that the ALJ has not sufficiently rejected, of some attempts at work, albeit not amounting to a significant work history.

C. Dr. Clayton

Plaintiff next argues that the ALJ improperly rejected medical expert Dr. Clayton's assessments which plaintiff argues establish that she is disabled. Dr. Clayton initially opined that absent

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[13] Moreover, in a recent case, the Ninth Circuit noted that

substance abuse, plaintiff would have marked impairment in maintaining concentration, persistence, or pace. Tr. 943. She based this on a combination of plaintiff's cognitive impairments and anxiety. Id. Dr. Clayton also stated that without access to medication for her PTSD, plaintiff's social functioning would be markedly impaired. Id.

Plaintiff argues that because she has not actually been on consistent medication treatment for PTSD, Dr. Clayton's testimony establishes that plaintiff is in fact disabled. Because her impairments satisfy the "A" criteria of multiple mental health impairment listings, and Dr. Clayton's testimony shows she is markedly impaired in two of the "B" criteria, plaintiff argues that she meets all criteria for a listed impairment.

Dr. Clayton's testimony is problematic. At first, she concludes that plaintiff has mild mental retardation. Tr. 939. Then, as recited above, she discussed Dr. Tinker's WAIS-III results and Dr. Bryan's WAIS-III results, and the validity of those results. Tr. 939-42. Then, she opined that without drug and alcohol use, plaintiff would be markedly impaired in concentration, persistence, and pace. Tr. 943. She also concluded that with access to PTSD medications, plaintiff would be moderately impaired in social functioning and mildly impaired in activities of daily living. Id.

Dr. Clayton's testimony is reviewed above. Her testimony is vague as to whether she considered plaintiff's concentration, persistence, and pace to be moderately impaired absent borderline intellectual functioning or with borderline intellectual functioning.

But, most importantly, her testimony was unequivocal that with an impairment of mild mental retardation, plaintiff had marked impairment in concentration, persistence, and pace. Tr. 943. The ALJ found that plaintiff suffers from mild mental retardation. Tr. 116. Given the ALJ's own assessment of plaintiff's cognitive functioning, it was error for the ALJ to reject Dr. Clayton's opinion that in the presence of such a cognitive impairment, plaintiff had marked impairment in her abilities of concentration, persistence, and pace.

Additionally, Dr. Clayton found that without access to her medication for PTSD, plaintiff's social functioning would be markedly impaired. Tr. 943. As discussed above, given the ALJ's erroneous finding regarding plaintiff's access to medications, it was error for the ALJ to disregard Dr. Clayton's assessment of plaintiff's functioning absent access to medications.

III. Rejection of Plaintiff's Testimony

Plaintiff contends that the ALJ erroneously rejected her testimony about hearing voices and an inability to get along with others. Tr. 115. The ALJ explained that

> claimant has successfully spent periods of time incarcerated, emerging without injuries or records of inability to get along with other prisoners. She reportedly is homeless and spends a great deal of time on the streets. She has told some doctors that she has been attacked and victimized while on the street, but there are no police reports or claims filed by her. She has, quite the opposite, been able to procure crack cocaine and alcohol, despite living on the street. In short, she appears to have incredible socialization skills to exist in varied and unsecure [sic] environments.

Tr. 118.

This reasoning by the ALJ is baseless. First, the ALJ speculates as to the quality of the time plaintiff spent in jail

and her ability to function there. Jailers do not routinely keep records of inmate sociological and psychological functioning on a day-to-day, or any other, basis. There is simply no evidence in the record, one way or the other, regarding her behavior or discipline while incarcerated. The ALJ's conclusion that plaintiff must be lying about being attacked or victimized while living on the streets because no police reports substantiate those incidents, is also based on speculation. There is a plethora of reasons as to why a police report may not be filed and to assume that plaintiff is fabricating her testimony in this regard is not supported in the record. The record is silent regarding the issue of how frequently, or infrequently, homeless crime victims file police reports.

Second, the ALJ's conclusion that a homeless person with mild mental retardation and PTSD, impairments the ALJ himself assessed, has "incredible socialization skills" because that person managed to obtain crack and alcohol while living on the street, is ludicrous. It is also completely unsupported by any factual evidence or expert opinion in the record.

Third, the ALJ's other comments regarding plaintiff's lack of credibility, such as her physical pain complaints being unsupported by the medical evidence, and Dr. Bryan's comments regarding her exaggeration on psychological testing, do not afford the ALJ a basis upon which to reject her testimony regarding her ability to get along with others. Unless there is affirmative evidence of malingering, the ALJ's reasons for rejecting plaintiff's testimony must be "clear and convincing." Reddick v. Chater, 157 F.3d 715, 722 (9th Cir. 1998). The ALJ must identify what testimony is not

credible and what evidence undermines the plaintiff's complaints. Id. The evidence upon which the ALJ relies must be substantial. Id.

Here, Dr. Bryan stated that no clear diagnostic conclusions could be drawn due to her invalid engagement in testing. Id. Importantly, as noted above, the incomplete page with his assessment suggests the possible provisional diagnosis of malingering, but also makes references to a somatoform disorder and other significant functional impairments notwithstanding that provisional diagnosis. Tr. 693.

Presently, there is no "affirmative evidence" conclusive of malingering. Therefore, the ALJ was required to articulate clear and convincing reasons for his rejection of plaintiff's testimony regarding her inability to get along with others. As noted above, the ALJ failed to support this rejection with substantial evidence.

IV. Remand for Benefits

The court has discretion to reverse the Commissioner's final decision with or without a remand for further administrative proceedings. Harman v. Apfel, 211 F.3d 1172, 1177 (9th Cir. 2000). When an ALJ improperly rejects evidence, the court should credit such evidence and remand for an award of benefits when: "'(1) the ALJ failed to provide legally sufficient reasons for rejecting such evidence, (2) there are no outstanding issues that must be resolved before a determination of disability can be made, and (3) it is clear from the record that the ALJ would be required to find the claimant disabled were such evidence credited.'" Moore v. Commissioner, 278 F.3d 920, 926 (9th Cir. 2002) (quoting Smolen, 80 F.3d at 1292).

Here, the ALJ first failed to provide legally sufficient reasons for determining that plaintiff's intermittent access to medications was due willful non-compliance and for determining that she would not meet the twelve-month duration requirement because she could rely on obtaining sample medications from community resources. The ALJ affirmatively stated that without access to medications, plaintiff was disabled. Thus, remand for additional proceedings would be futile.

The ALJ next failed to provide legally sufficient reasons for rejecting Dr. Tinker's, Dr. Colistro's, and Dr. Clayton's testimony. When that testimony is credited, it establishes that plaintiff is disabled.

Finally, the ALJ failed to provide legally sufficient reasons for rejecting plaintiff's testimony that she could not maintain employment based in part on her inability to get along with people. While that testimony, when credited, may not alone establish disability, it is supportive of findings made by the examining psychologists.

CONCLUSION

The Commissioner's decision should be reversed and remanded for a determination of benefits.

SCHEDULING ORDER

The above Findings and Recommendation will be referred to a United States District Judge for review. Objections, if any, are due July 10, 2008. If no objections are filed, review of the Findings and Recommendation will go under advisement on that date.

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If objections are filed, a response to the objections is due July 24, 2008, and the review of the Findings and Recommendation will go under advisement on that date.

IT IS SO ORDERED.

DATED this 25th day of June, 2008.

/s/ Dennis James Hubel
Dennis James Hubel
United States Magistrate Judge